1. Collaboration Name: Cook County Health Peer Advocate Liaison (PAL) Support Grant

2. Name of Lead Entity: Cook County Health

3. List All Collaboration Members: Cook County Health, BEDS Plus Care, Heartland Alliance Health, Live4Lali, Housing Forward, Safer Foundation, WestCare Illinois, Greater Chicago Food Depository

4. Proposed Coverage Area: Cook County

5. Area of Focus: City of Chicago

6. Total Budget Requested: $31,098,596.98

Project Description

0. Start Here - Eligibility Screen

Does your collaboration include multiple, external, entities? ○ Yes
○ No

Can any of the entities in your collaboration bill Medicaid? ○ Yes
○ No

1. Participating Entities

Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative? Cook County Health Peer Advocate Liaison (PAL) Support Grant

1. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Tax ID # (xx-xxxxxxx)	Primary Contact	Position	Email	Office Phone	Mobile Phone	Secondary Contact	Secondary Contact Position	Secondary Contact Email
Cook County Health		Andrea Gibson	Chief Strategy Officer				Shannon Andrews	Chief Equity and Inclusion Officer	
BEDS Plus Care		Tina Rounds	Chief Executive Officer				Julie Daraska	Director, Grants & Contracts	
Heartland Alliance Health		Ed Stellon	Executive Director				Mary Kay Gilbert	Chief Business Officer	
Live4Lali		Laura Fry	Executive Director				Scott Meno	Director of Operations	
Housing Forward		Lynda Schueler	Executive Director				Colleen Luckey	Grants Manager	
Safer Foundation		Rucha Shastri	AVP				Sodiqa Williams	SR VP	
WestCare Illinois		Stacy Munroe	Regional Vice President				John Zidek	Community Treatment Director	
Greater Chicago Food Depository		Amy Laboy	Senior Director of Programs				Emily Daniels	Associate Director of Client Services - Meal Programs	

2. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.
○ I confirm

3. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)
990 Forms

Participating Entities

1. Are there any primary or preventative care providers in your collaborative? ○ Yes
○ No

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.
Cook County Health

2. Are there any specialty care providers in your collaborative? ○ Yes

○ No

2A. Please enter the names of entities that provide specialty care in your collaborative.
Cook County Health

3. Are there any hospital services providers in your collaborative? ○ Yes
○ No

Note: HFS is seeking to know in which MCO networks each hospital in your collaborative participates.

3A. Please enter the name of the first entity that provides hospital services in your

collaborative.
Cook County Health

3B. Which MCO networks does this hospital participate in?
☐ YouthCare
☐ Blue Cross Blue Shield Community
☐ Health Plan CountyCare Health Plan
☐ (Cook County only) IlliniCare Health
☐ Meridian Health Plan (Former Youth in Care
☐ Only) Molina Healthcare

3C. Are there any other hospital providers in your collaborative? ○ Yes
○ No

3D. Please give the name of your second hospital

provider here. 3E. Which MCO networks does this

hospital participate in?
☐ YouthCare
☐ Blue Cross Blue Shield Community
☐ Health Plan CountyCare Health Plan
☐ (Cook County only) IlliniCare Health
☐ Meridian Health Plan (Former Youth in Care
☐ Only) Molina Healthcare

3F. Are there any other hospital providers in your collaborative? ○ Yes
○ No

3G. Please give the name of your third hospital

provider here. 3H. Which MCO networks does this

hospital participate in?

☐ YouthCare
☐ Blue Cross Blue Shield Community
☐ Health Plan CountyCare Health Plan
☐ (Cook County only) IlliniCare Health
☐ Meridian Health Plan (Former Youth in Care
☐ Only) Molina Healthcare

3I. Are there any other hospital providers in your collaborative? ○ Yes
○ No

3J. Please give the name of your fourth hospital

provider here. 3K. Which MCO networks does this

hospital participate in?
☐ YouthCare
☐ Blue Cross Blue Shield Community
☐ Health Plan CountyCare Health Plan
☐ (Cook County only) IlliniCare Health
☐ Meridian Health Plan (Former Youth in Care
☐ Only) Molina Healthcare

3L. Are there any other hospital providers in your collaborative? ○ Yes
○ No

3M. Please give the name of your fifth hospital provider

here. 3N. Which MCO networks does this hospital

participate in?
☐ YouthCare
☐ Blue Cross Blue Shield Community
☐ Health Plan CountyCare Health Plan
☐ (Cook County only) IlliniCare Health
☐ Meridian Health Plan (Former Youth in Care
☐ Only) Molina Healthcare

3O. If there are any other hospitals in your collaborative, please list them all here, together with a list of MCO networks which each participates in.

4. Are there any mental health providers in your collaborative? ○ Yes
○ No

4A. Please enter the names of entities that provide mental health services in your collaborative.
Cook County Health

5. Are there any substance use disorder services providers in your collaborative? ○ Yes
○ No

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.
Cook County Health, WestCare, Live4Lali

6. Are there any social determinants of health services providers in your collaborative? ○ Yes
○ No

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

Heartland Alliance Health, Beds Plus, Housing Forward, Safer Foundation

7. Are there any safety net or critical access hospitals in your collaborative? ○ Yes
○ No

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative. Cook County Health

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities?
○ Yes
○ No

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities.

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.
Cook County Health

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).
☐ Safety Net Hospital Partnerships to Address Health Disparities
☐ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
☐ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as
significant partners)
☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit
☐ Organizations Workforce Development and Diversity Inclusion Collaborations
☐ Other

10A. If you checked, "Other," provide additional explanation here.

[10A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Project Description

Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application. Cook County Health Peer Advocate Liaison (PAL) Support Grant

2. Provide a one to two sentence summary of your collaboration's overall goals. Cook County Health (CCH) proposes a concept of whole-person care that engages community organizations in greater coordination for delivery of service.

Detailed Project Description

Provide a narrative description of your overall project, explaining what makes it transformational.

Through a participatory stakeholder process, community organizations provided input and insights to develop a program model that will center around CCH patients, justice-involved individuals and CountyCare members for a whole-person response when needing health care. Organizations represent the following areas of service: mental health, maternal and child health, substance use disorder, food security, housing security, justice-involved and legal services.

Through a series of focus groups and written surveys, organizations identified several needs of and recommendations for how Cook County citizens (including CountyCare patients) can receive improved medical care and wraparound support.
• Mental health requires ongoing and critical need assessments to accompany healthcare evaluations
• Cook County Health can serve as a community hub and partner with multiple partner agencies offering navigation and technology coordination
• Patients/members are more likely to connect and follow through with treatment plans and follow-up visits when treated with dignity in environments that reduce stigma
• Patients/members will benefit from knowing how to advocate for themselves in multiple, intersecting systems
• An integrated system that prevents offerings of repeated services and multiple points of contact will increase efficiency and outcomes for patients and members
• Centering employees with a whole-person approach to healthcare will improve medical outcomes and mitigate environmental and social determinants of health

These findings support development of a whole-person approach, centered on hiring Patient Advocate Liaisons, and using an existing technological investment to transform the healthcare experience for Cook County citizens (including CountyCare members). **Patient Advocate Liaisons – PALs –** will catalyze a responsive whole-person approach to healthcare that simultaneously addresses critical medical concerns, social determinants of health, and equips patients to self-advocate in their navigation of intersecting health and support systems. Community partners with expertise in mental health, maternal and child health, substance abuse, food and housing security, justice-involved populations, and legal aid will staff PALS for patients through the Illinois Healthcare Transformation grant. Within this consortium of expertise, PALs will gain additional subject expertise to support patients/members in navigating their path through several of these issue areas, along with receiving medical care. PALs help to coordinate care, support services, and model and educate patients on advocating for themselves and managing intersecting systems to address basic needs (housing, food, etc.) and health care.

The consortium of community partners will collaborate with Cook County Health, leveraging an already-developed technology development, to serve patients. The services offered will include mental health, and as patients/members identify other challenges, a single PAL will help them navigate multiple systems and agencies with a walking hand-off instead of only a referral. The walking hand-off is concerted time and attention to ensure that patients/members directly connect to the next agency or service provider, using the existing case notes and pertinent details, without having to fully re-tell their story from the beginning. The walking hand-off assures pertinent details are being transferred and is serving the patient with dignity by limiting direct and vicarious trauma from the act of retelling, and frustration with multiple, mirrored systems.

An earlier investment by Cook County Health in a technology platform will enable collaborative, real-time communication, and efficiency.

3. Governance Structure

Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

CCH is the lead organization of this project. Andrea Gibson, CCH Chief Strategy Officer, will serve as the point person for this proposal. CCH will hire a project manager to ensure every-day activities are managed and will be the point of contact for all partner organizations. Each partner organization is responsible for the internal training and supervision of each PAL. Each organization is responsible for developing a brief training that will be taught to partner organization PALs.

Each organization will have a representative that will participate in consortium-wide meetings, called the Project Management Team. These meetings will be held monthly during the planning phase and will transition into quarterly meetings once the project is fully implemented. All policies and procedures will be developed by the consortium as a whole to ensure equity among members.

Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

A project manager at CCH will be hired to oversee all activities of the project. This position will be tasked with managing all partner organizations to ensure that activities are be accomplished. Monthly check-ins with each partner organization will be established, at least in the beginning, to ensure fidelity of the proposal as well as uniform implementation. If challenges arise, the project manager will be altered as soon as possible and the partner organization or the consortium as a whole will be convened to troubleshoot.

In addition, this project will be engaged with Cook County Health System Corporate Compliance Program, which will ensure integrity of the project. Cook County Health System Corporate Compliance Program incorporates two (2) distinct Compliance Programs: encompassing CCH as a provider of health care services in addition to the public health department and the CountyCare Medicaid Health Plan with executive oversight of both programs by a Chief Compliance & Privacy Officer. In looking at the breadth of Compliance at CCH, system-level services occur within both CCH hospitals (John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County), multiple outpatient clinics, correctional medicine at the Cook County Jail and Juvenile Temporary Detention Center, and the Cook County Department of Public Health. It also includes providers, clinicians and others that provide direct care to patients, in addition to workforce members not directly involved in patient care. In an indirect way, Corporate Compliance also encompasses all of CCH's "business associates" – parties who have contracted with CCH and have access to our patients' and members' protected health information in varying capacities. Although the CountyCare Medicaid Health Plan's Compliance Program is addressed through a separate annual report, both programs are organized to function at the overarching organizational level and are designed to promote a culture of compliance within CCH as a whole. Corporate Compliance has outlined and enforced the expectation that all workforce members are responsible for prevention, detection, and reporting of instances that may not comport with state, federal, or local law, or CCH policy.

New Legal Entity

3. Will a new umbrella legal entity be created as a result of your collaboration? ○ Yes
○ No

3A. Please give details on the new entity's Board of Directors, including its racial and ethnic make-up.

Cook County Health's Board of Directors is comprised of a diverse group of professionals that represent the communities that we serve. The CCH board identifies as 33% female, 25% White, 16.7% LatinX, 50% Black, and 8.3% Asian.

Payments and Administration of Funds

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

Given that CCH is a large institution, mechanisms have been established to coordinate grant administration with the Finance Department for fiscal activity, Purchasing Department for resource and service procurement, Legal Services for contract negotiations and Human Resources to timely hire for designated grant positions. The chart attached shows how the administration and the fiscal management of the proposed project will be integrated into the current administration.

4. Racial Equity

High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity.

As Ta-Nehisi Coates so eloquently described in his article "The Case for Reparations" in The Atlantic (2014), Chicago has a storied past of racist structures that have divided the people of Chicago for centuries. Coates explicitly outlines the City's discrimination against Blacks through redlining practices, block busting, mortgage exploitation, and sheer racism. Although these practices are now illegal, the structural barriers are still in place, favoring white neighborhoods to Black neighborhoods specifically around employment, affordable housing, food security, and transportation. In Garfield Park, six miles of Chicago's downtown Loop, there is a 16-year life expectancy gap. CCH is acutely aware of the barriers its patients and employees face on a day-to-day basis. To increase access to care, all 12 of CCH's community health centers are in disadvantaged neighborhoods that have been directly impacted by the historical exploitation and systemic barriers against people of color.

Chicago is home to a diverse community of individuals. Many needed medical care and often were discriminated against because of their background. Cook County Hospital soon became a place of medical refuge in Chicago. Cook County Hospital (now Cook County Health), opened 1834 and was used as a teaching hospital by Rush Medical School until the Civil War, when it was transitioned to an army hospital. After the war, it continued its purpose as a center for medical education and founded the first medical internship in the country in 1866. By the 1900s, the hospital was overseen by surgeons and physicians in Chicago who volunteered their services at the hospital, which was rebuilt in 1916. Regarded as one of the world's greatest teaching hospitals, many interns, residents, and graduate physicians came to see the medical and surgical advances. Innovations included the world's first blood bank and surgical fixation of fractures. Today, Cook County Health's mission is to "deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies, which promote and protect the physical, mental, and social well-being of the people of Cook County."

Racial Equity Impact Assessment Questions

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

Black and LatinX ethnic groups are most affected.

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Many partner organizations have individuals with lived experience working with them and have engaged in the development of this proposal. This proposal is a reflection of the needs of the communities CCH and organizations serve; therefore it is imperative that the diversity of the communities is represented. As the project moves forward, feedback from patients will be used to inform the rapid-cycle improvement strategy process and will shape the implementation and continued work.

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Current day health inequities derive from long-standing political and economic practices in Chicago. For many Chicagoans, race, income, and insurance affect access to care across many conditions and contribute to excess deaths, particularly in predominantly Black and Brown neighborhoods. Dr. David Ansell writes "At Rush, the right insurance card provides access to world-class health care and just about any service imaginable. But if you have the wrong insurance card at Rush (or no insurance card), access to some doctors and services is blocked. At Stroger, a patient receives the best care the hospital has to offer without regard to ability to pay, but often after a mind-numbing wait." Socioeconomic barriers, such as insurance, have contributed to who receives appropriate and timely care. Because of systemic racism in Chicago and Cook County, people of minority status have often been marginalized and not been able to access the care they deserve. This has translated to some hospitals seeing patients with more complex needs, often patients of color.

Examining inpatient hospitalization rates among CCH patients, almost 48% of cases at Stroger Hospital identified as Black, compared to 17% at similar, large complex care medical centers, and 22% at America's Essential Hospitals. Likewise, almost 26% identified as Hispanic at Stroger compared to 7.6% at large hospitals and 20% at America's Essential Hospitals. When it comes to chronic disease, black and brown rates at Stroger are significantly higher than comparable hospitals and national averages (heart failure: 62% vs 25% vs 62% for Blacks, 26% vs 8% vs 16% for

Hispanics; type II diabetes: 41% vs 21% vs 26% for Blacks, 43% vs 10% vs 20% for Hispanics; stroke: 55% vs 18% vs 25% for Blacks, 30% vs 6% vs 12% for Hispanics).

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Historic racism of Chicago and Cook County have significantly contributed to this disparity. Redlining, block busting and physical location of medical care have significantly contributed to racial disparities. A pamphlet published in 1954 outlines the systemic racism of Chicago Hospitals with regard to births and deaths as well as routine medical care. A map of Chicago depicts the 22-mile route that a sick Black patient in the Altgeld Gardens neighborhood on Chicago's far south side would have to travel to get to Cook County Hospital, bypassing 28 closer hospitals en route. The trip would take about 1 hour and 20 minutes. The text speaks to the racist policies created by hospitals to restrict black admissions by limiting the number of beds designated for Black patients. This is also the first mention of "patient dumping", where sick Black patients were transferred to Cook County Hospital simply because of racism and poverty.

This proposal does not directly treat the chronic disease of racism in Chicago and Cook County; however it does alleviate some of the symptoms by tightening the social safety net that many patients of color utilize. This is done by the implementation of the PAL model, having multiple community organizations partner with CCH and creating a platform where patient tracking can be utilized across all agencies. Creating a true patient-centered model will hopefully reduce chronic and acute health outcomes as well as improve patient well-being as social needs are being catered to.

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The CCH PAL proposal seeks to develop a program model that will center CountyCare, CareLink patients (CCH's financial assistance program for uninsured patients), and out of care patients for a whole-person response when needing health care. Organizations represent the following areas of service: mental health, maternal and child health, substance use disorder, food security, housing security, justice-involved and legal services. This proposal aims to reduce disparities in these areas by creating a comprehensive coordination of care via the PAL model.

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

As with any social service intervention, there could be unintended consequences. Safeguards will be put in place to ensure when adverse issues arise, they will be identified and resolved in a timely manner. Such safeguards would be working with CCH Compliance Department, monthly meetings with stakeholders, quality performance measures, and qualitative interviews with staff and patients.

Potential consequences are unintended shame patients may have utilizing the services provided by the grant or adverse mental health issues. The purpose of the PAL model is to have that position employed by someone with lived experience and someone from the patient's community. This will lessen the stigma associated with service utilization and will allow for a positive relationship between the PAL and patient. In addition, behavioral health providers will be on hand to assist with any significant mental health issue.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

There may be ways to better solve health disparities and CCH is open to exploring options to best serve Cook County's most vulnerable patients. With this proposal, CCH is attempting to promote equity for their employees, patients/members and community by enhancing and expanding care coordination. A way to be more inclusive is through engagement of multiple stakeholders representing various backgrounds and areas. An example of this is of CCH's approach to opioid use disorder.

CCH has been innovative in addressing various health disparities through a multi-disciplinary approach. CCH has identified disparities that have disproportionality affected the people of Cook County- opioid use disorder (OUD) and food insecurity. CCH addresses both of these areas through a multi-faceted lens. CCH currently provides identification, screening, and linkage to recovery support services for patients with SUD in a variety of settings, as many of CCH's patients have screened positive for OUD (over 1,000/month). CCH has addressed social inequities of OUD through the Cook County minimum wage ordinance and addressing stigma of substance use disorders (SUD); addressed institutional inequities through adult probation policies at the Cook County Jail; and addressed living conditions by expanding access to medication assisted treatment (MAT); and has addressed risk behaviors by implementing individual provision of MAT and access to naloxone. For food insecurity, CCH addressed social inequities by opposing SNAP changes that negatively impact beneficiaries; institutional inequities by implementing a Good Food Purchasing Program; living conditions by implementing screening and referral of patients to Fresh Trucks ; and risk behaviors by instituting individual health education seminars.

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation

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and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

CCH has a long history committed to advancing equity through the expansion of affordable access to healthcare as well as working to address social disparities patients face. The Center for Health Equity and Innovation (Center) aim is to identify and advance strategies, initiatives, and programs that improve health equity throughout Cook County. The Center's goals are to promote justice and equity, convene experts in data and analytics, as well as community leaders, and align resources to develop effective, sustainable long-standing gains towards achieving health equity. The Center works to translate ideas that align with CCH's Strategic Priorities and to serve as an in-house innovation center that facilitates implementation of new ideas from clinical and research staff. Currently, the Center manages 60 plus groundbreaking projects totaling over $44 million in funds from federal and state government agencies, public and private foundations, and other non-profit entities. The Center is supervised by the Chief Equity and Inclusion Officer.

The Center houses CCH's Health Research and Solutions Unit which surveys health trends of Cook County and identifies on equity gaps. In conjunction with Cook County Department of Public Health, the Center generates reports and shares the information with the community by publishing articles and hosting "summits" that invites community members and other stakeholders to listen to a panel of experts on the topic of that summit. Previously held summits include housing insecurity, the opioid epidemic, justice involved adults, and institutional racism. These initiatives have taken place at both the strategic and clinical level, in which multiple departments within CCH have worked together to bridge the siloed nature of hospitals and have resulted in positive clinical outcomes.

This proposal is building upon an existing infrastructure at CCH. The Care Coordination Department is efficient and effective at reducing adverse health outcomes and assisting patients with social needs. Unfortunately, the department is at capacity and can only serve CountyCare patients. This proposal seeks to expand these services by hiring additional staff to serve CareLink and uninsured patients- some of the system's most vulnerable and costly patients. In addition, this proposal aims to enhance the current CMIS platform which tracks patients within Cook County Health. The proposed enhancement is for our community partners to have access to this software and be able to track and see what services- both medical and social- patients need and utilizing. This will ultimately lead to a more comprehensive coordination of care. This data will be continuously monitored by the data manager and will be shared at monthly and quarterly meetings with partnering organizations. This data will serve as a check point to see if patient care is most efficient and effective at reducing social disparities and adverse medical outcomes.

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Benchmarks for this proposal are patient dependent as this is a patient-centered proposal however larger, public health outcomes and trends will be monitored. Trends of points of care and needs will be assessed. An example of this is if someone is in need of housing but did not engage with a housing partner. Qualitative interviews with patients will be used to see what gaps still exist in this model and how the consortium as a whole can rectify. Along with the collection of performance measures (see later in the proposal) the qualitative interviews and/or focus groups with providers and patients will inform the implementation and continued work of the project- ultimately feeding the rapid-cycle improvement strategy.

5. Community Input

Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois"). City of Chicago

2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)

Select counties: COOK

3. Please list all zip codes in your service area, separated by commas.

60657, 60614, 60640, 60647, 60618, 60613, 60610, 60625, 60629, 60611, 60619, 60617, 60620, 60634, 60016, 60628, 60626, 60649, 60622, 60616, 60615, 60641, 60660, 60453, 60056, 60637, 60608, 60004, 60639, 60402, 60638, 60605, 60630, 60643, 60411, 60804, 60201, 60632, 60623, 60607, 60010, 60654, 60609, 60062, 60089, 60645, 60462, 60067, 60651, 60193, 60707,
60120, 60477, 60025, 60653, 60644, 60090, 60302, 60068, 60409, 60074, 60103, 60612, 60202, 60007, 60107, 60005, 60659,
60652, 60525, 60169, 60624, 60631, 60527, 60656, 60714, 60438, 60076, 60642, 60133, 60601, 60621, 60077, 60655, 60018,
60646, 60636, 60452, 60091, 60827, 60467, 60172, 60466, 60706, 60459, 60053, 60803, 60406, 60487, 60439, 60008, 60661,
60426, 60443, 60430, 60194, 60419, 60473, 60130, 60093, 60153, 60513, 60160, 60465, 60805, 60154, 60164, 60304, 60070,
60546, 60173, 60104, 60131, 60521, 60478, 60455, 60463, 60415, 60429, 60458, 60026, 60192, 60526, 60445, 60457, 60471,
60418, 60633, 60482, 60712, 60558, 60176, 60171, 60305, 60475, 60534, 60428, 60464, 60422, 60425, 60155, 60501, 60162,
60022, 60606, 60195, 60480, 60680, 60461, 60456, 60301, 60163, 60469, 60472, 60203, 60165, 60603, 60476, 60690, 60043,
60602, 60204, 60303, 60604, 60412, 60141, 60454, 60078, 60006, 60161, 60011, 60065, 60017, 60168, 60009, 60029, 60159,
60499, 60664, 60699, 60095, 60082, 60666, 60597, 60663, 60668, 60670, 60669, 60674, 60673, 60677, 60675, 60679, 60678,
60681, 60684, 60682, 60686, 60685, 60688, 60687, 60689, 60693, 60691, 60695, 60694, 60697, 60696, 60701, 60019, 60038,
60055, 60094, 60105, 60179, 60196, 60209, 60208, 60398, 60290

Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

Community co-design and Mobilizing for Action through Planning and Partnerships (MAPP) processes were used to inform the strategic plan for the IL Healthcare Transformation grant. Community co-design, through action committees, is a way for groups of communities, organizations, and/or health systems to come together to begin or accelerate their efforts to achieve results on a specific health, well-being, or equity topic in a relatively short period of time (on average, 7 to 12 months). These groups, referred to as "Teams" in an Action Community, come together in virtual and/or in person ways around a specific topic to test ideas, learn together, and make progress -- all while supported by facilitators. An Action Community is based on pre-established "core content" (including a theory of change and measures) and involves committed Teams that want to test and implement that theory and measurement in their settings. The Action Community model was developed via the Age-Friendly Health Systems Initiative at the Institute for Healthcare Improvement (IHI).

Mobilizing for Action through Planning and Partnerships (MAPP) process, a community-driven strategic planning process for improving community health. This framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. Assessments would include the Community Health Status Assessment, Forces of Change Assessment, Community Themes and Strengths Assessment, and Local Public Health System Assessment. In addition, three community and one CCH stakeholder focus groups and a mixed-methods survey were deployed to gain community feedback.

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal? ○ Yes
○ No

6. Data Support

1. Describe the data used to design your proposal and the methodology of collection.

CCH utilized several evidence-based models to design our proposal. CCH did a systematic review of community assessments of the Chicagoland and Cook County. This systematic review included community data reports produced by UIC, our community partners (i.e. Westside United, United Way Chicago, Chicago Greater Food Depository, University of Chicago, Rush Medical Center- please see attached spreadsheet), and an internal audit of programmatic and clinical areas that our most vulnerable patients use. In addition, three community and one CCH stakeholder focus groups and a mixed-methods survey were deployed to gain community feedback.

7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

Cook County Health (CCH) is one of the nation's largest public integrated healthcare delivery systems serving the 132 contiguous urban and suburban municipalities of Cook County including the City of Chicago. CCH operates two hospitals, twelve community health centers, correctional healthcare services for the county jail and juvenile detention center, a comprehensive medical home for patients with HIV/AIDS, and the Cook County Department of Public Health, serving suburban Cook County. CCH also administers CountyCare, a Medicaid managed care plan for Cook County residents, which serves nearly one in every 10 Cook County residents with Medicaid. Patients seen at CCH's sites are economically disadvantaged minorities, many who are not traditionally connected to a regular healthcare provider. Currently, 47% of patients are uninsured, and 38% are insured through Medicaid. 50% of patients are African American, 37% White, 33.5% Hispanic, 2% American Indians/Alaskan Natives, 4% Asian, 0.5% multiple, 0.08% Native Hawaiian/Pacific Islander, and 7% Other ethnic or racial minorities. About 30% of CCH patients speak a language other than English at home. The average breakdown of the patient population is as follows: 6.60% < 0-20 years, 8.51% 21-30 years, 11.16% 31-40 years, 16.56% 41-50 years, 25.45%, 51-60 years, and 31.46% 60+ years. In Cook County, the median household income is $59,426, and 16% of individuals live below the poverty line.

In the spring of 2020, the CCH Board of Directors tasked CCH to address inequities within the health system by forming a Racial and Health Equity Initiative (RHEI). This a part of a project lead by the Center of Health Equity and Innovation (Center) at Cook County Health. The Center is a point of collaboration for cross-sector engagement to address and mitigate social determinants of health in new and innovative ways through research and programmatic services. The Center's responsibility is to foster a collaborative learning environment and continued engagement with the community. The Racial and Health Equity Initiative (Initiative) is joint effort with the Center that includes an internal group of multidisciplinary staff representing all entities within CCH developing a comprehensive strategy to address health equity for patients, employees, and community. The goals of the Initiative are to 1) Gather input from internal stakeholders; 2) Review and broadly share current initiatives that addresses health equity across the system; 3) Develop a community co-design committee to guide plan development; 4) Gain scholarship from Institute of Health Improvement funding participation in a national Pursing Health Equity Learning Network; and 5) Organize online forum regarding health equity.

Activities accomplished from this group include receiving funding from the Illinois Department of Human Services in partnership with The Chicago Community Trust to conduct racial healing circles at Provident Hospital and the South and West Side communities as well as scholarship and guidance from the Institute of Healthcare Improvement to internally investigate areas where CCH can be more meaningful in addressing inequity. The RHEI polled CCH leadership, CCH Community Advisory Councils, patients, employees and community members. From these efforts, six healthcare pillars have been identified: a) SUD/Opioid use, b) Maternal/Child health, c) Housing security, d) Food security, e) Justice involved, and f) Mental health. We know that these issues are not siloed; the patients that we serve have high and complex needs. For example, with patients transitioning out of Cook County Jail within a 6-year period, 28.8% identified as having a substance use disorder, 28.3% with a serious mental illness and 40.1% of both. Additionally, out of uninsured patients screened at CCH in 2019, 91% reported that they had food but it didn't last the week.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Patient Advocate Liaisons – PALs – will catalyze a responsive whole-person approach to healthcare that simultaneously addresses critical medical concerns, social determinants of health, and equips patients to self-advocate in their navigation of intersecting health and support systems. The PAL is similar to a recovery coach and a community health worker- they will be someone with lived experience and representative from the communities served. The reason behind the name is that it takes the hierarchy out of the patient and navigator or coordinator relationship; it has a neutralizing effect with respecting the dignity of the patient. Community partners with expertise in mental health, maternal and child health, substance abuse, food and housing security, justice-involved populations, and legal aid will staff PALs for patients through the Illinois Healthcare Transformation grant. Within this consortium of expertise, PALs will gain additional subject expertise to support patients in navigating their path through several of these issue areas, along with receiving medical care. PALs help to coordinate care, support services, and model and educate patients on advocating for themselves and managing intersecting systems to address basic needs (housing, food, etc.) and health care.

7. Health Equity and Outcomes

The PALs are connectors and navigators for patients requiring multiple health and wellness services. They provide *walking hand-offs* for patients between agencies when multiple services are needed. This is an accompaniment model that respects the dignity of the patient. PALs will utilize patient management technology system owned and sponsored by Cook County Health to coordinate a whole-person approach to healthcare and provide case management for up to 60 patients. Each PAL will be cross-trained with other partner agencies to gain additional subject-matter expertise and participate in annual quality improvement assessments and planning.

The Health Research & Solutions (HRS) unit for Cook County Health developed and delivered a care management software application to be used by the Chronic Care Coordination team for managed care members seeking care at Cook County Health. The system was developed internally to allow scalability to new populations, flexibility in adding new instruments and modules, and integration with health system and jail data. This is a novel system in that most health systems use vendor-built systems that do not integrate well with other data systems and are expensive to modify and build for novel populations. HRS has over 15 years of experience building informatics solutions for service and research grants and incorporating the work into clinical activities. The CMIS system is characterized by the following attributes:

- Modular, we have added modules for the following populations:
  - Juvenile detention center detainees
  - COVID tracing
- Integrated with clinical research database that includes millions of records documenting demographics, schedules, visits, medications, diagnostic & procedure codes, laboratory results, immunizations
  - No data use agreements required for data integration
  - Master database with Institutional Review Board (IRB) approval
  - Data mapped to the PCORnet (the National Patient-Centered Clinical Research Network) and OMOP data models (a data model that allows for the systematic analysis of disparate observational databases)
- Patient addresses routinely cleaned and geocoded daily through automated procedures
  - Person-level geocodes linked to the American Community Survey census tract database and we routinely calculate CDC's social vulnerability index.
- We are in the process of integrating external behavioral health referrals
- Collaboration with institutional teams
  - Business Intelligence Group that manages the Enterprise Data Warehouse
  - Central Information Systems
    - Data Center: 10+ Virtual servers for development, testing & production
  - Corporate Compliance: Approved Privacy Controls
- Evidence based NCQA approved assessments, problems, goals, and activities
  - Currently 30+ Assessments (Adult and Pediatric) deployed
- Real-time Analytics and Reports:
  - Power BI Gateway Servers and Licenses for front end decision support reports
  - Application built-in audit tool with real-time data validation checks
  - Automatically generated reports sent to Health Plans
- E-signature and Voice-Signature features
- Data Integration: automated data feeds from over five external sources
- Scalable Business Logic engine
  - Over 40 automated rules
    - Customized Rules are added/removed as need

The CMIS system is a central depository that is accessible by our community partners to track in real time where patients are. As part of the institutional infrastructure, we are able to scale up new projects and deliverables under existing agreements, relationships, and approvals.

3. Why will the activities you propose lead to the impact you intend to have?

By bridging the existing gaps in a fractured social service delivery system, this will allow for more individuals to be able to access the resources they need as well as the care they deserve. From anecdotal and clinical evidence, we know that care coordination works well when it is able to be done correctly and efficiently. Currently, CCH Care Coordinators are only assisting CountyCare members. The PAL model will allow for an expansion of the care coordination team to be inclusive of CareLink and out of care or uninsured patients. This model builds upon an

7. Health Equity and Outcomes

existing infrastructure that not only enhances but build capacity of that team to be able to best serve Cook County's most vulnerable patients, those with complex medical and social needs.

8. Access to Care

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

Through a series of focus groups, CCH and partners have identified the following as the most pressing issues in our community. Mental health access and lack of behavioral health workforce is a major issue, specifically, providers of color who share a lived experience with clients / patients of color. Other challenges identified is the lack of health literacy or social capital to navigate the complex and fragmented social service system which leads to lack of access of care, limited coordination between service providers and the lack of timeliness in service delivery. From our assessment, these are long-standing issues that have not been sufficiently addressed. This proposal aims to correct this by building upon existing care coordination and case management teams that will help create a cohesive transition of care among various organizations.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The PAL model includes organizations that are behavioral health providers while the PAL position explicitly recruits individuals from the community organizations serve and people with lived experience. By having PALs at multiple social service providers bridges the gaps the system has created and will provide a smooth and coordinated transition of care.

3. Why will the activities you propose lead to the impact you intend to have?

From anecdotal and clinical evidence, we know that care coordination works well when it is able to be done correctly and efficiently. The social service delivery system is complex and difficult to navigate. Care coordination alleviates this by being the central connector to services needed. Currently, CCH Care Coordinators are only assisting CountyCare members. The PAL model will allow for an expansion of the care coordination team to be inclusive of CareLink and out of care or uninsured patients. This model builds upon an existing infrastructure that not only enhances but build capacity of that team to be able to best serve Cook County's most vulnerable patients, those with complex medical and social needs.

9. Social Determinants of Health

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

Through a rigorous internal assessment of CCH leadership, CCH Community Advisory Councils, patients, employees and community members, CCH has identified six healthcare pillars to be addressed: a) SUD/Opioid use, b) Maternal/Child health, c) Housing security, d) Food security, e) Justice involved, and f) Mental health. These areas have been named through an exercise from CCH's using the Institute for Healthcare Improvement's Assessment Tool for Healthcare Organizations. The Institute for Healthcare Improvement (IHI) developed this assessment tool to help health care organizations evaluate their current health equity efforts and determine where to focus improvement efforts. Teams use this assessment to provide direction for building an equity strategy and promote conversations within the organization to improve health equity.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The proposed PAL program engages organizations who specialize in the reduction of the disparities listed above. This program allows for cross-training opportunities of PALs that lead to a comprehensive navigation of the social service safety net. This cross-training will educate PALs about the complex service delivery system of each sector and identify pathways of navigation. Increasing access to various social service agencies will allow for a better assessment of patient needs. By adding the whole-person approach of the PAL model, this will reflect the dignity of the patient. Quantitative metrics and qualitative interviews will inform the progress of the proposal.

3. Why will the activities you propose lead to the impact you intend to have?

Through an internal audit, we know that care coordination results in better health outcomes and patient satisfaction. By expanding and enhancing these services, while breaking disciplinary silos, this will lead to a more comprehensive coordination of care.

10. Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

The CCH PAL proposal is an expansion and enhancement of the existing Care Coordination team at Cook County Health. The Care Coordination team synchronizes the delivery of a patient's health care to achieve safe and more effective care with the primary goal of care coordination is to deliver high quality and high value health care. Our multidisciplinary care coordination team (nurse, social worker, and community health worker) collaborate with providers, specialists, and
community agencies, to share information and assist with social determinants of health needs, resulting in improved patient self-care needs.

Care coordinators assist patients not only within the practice, but between it and community settings, labs, specialists, and hospitals. They reach out and connect in meaningful ways with other sources of service and link with them, so that information is communicated appropriately and consistently. Key features resulting in value-based care and healthcare transformation are: 1) Link patients with community resources to facilitate referrals and address social determinants of health needs; 2) Integrate medical, behavioral health and specialty care resulting in continuity of care; 3) Patient centered care model; 4) Multidisciplinary teamwork supporting patients 'self-management goals; 5) Assessing social determinants of health needs, such as transportation, food, and housing assistance to improve patients' health and wellness; 6) Thorough needs assessment to elicit patients' concerns/care gaps, assess their functioning, and develop a patient centered care plan; 7) Screening and assessment methods using evidence-based medicine and care guidelines; and 8) CMIS (Care Management Information System) contains evidence-based care guidelines and tools, to address different social determinants of health needs and diseases. CMIS uses integrated data and knowledge management resulting in pertinent data sets for certain conditions and care coordination agreements.

The PAL model builds off of the current model by hiring individuals with lived experience, specifically from the communities that we serve, to serve patients as they navigate the complex social service network. The PAL model eliminates implicit hierarchy that exists in the delivery system and breaks down sector-based silos because of the cross-training that PALs receive. Currently, CCH Care Coordination team is limited to serving CountyCare members however the PAL model would be able to expand the current scope and serve CareLink and uninsured patients. In addition, the CMIS platform will be enhanced so that each community partner will have access and be able to track patients in real time.

2. Do you plan to hire community health workers or care coordinators as part of your
intervention? ○ Yes
○ No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).
The Care Coordination team currently only serves CountyCare members with an average caseload of 60. CountyCare members complete a Health Risk Screening that stratifies them as low, medium or high risk. Factors that would make a member medium or high risk are chronic medical conditions, behavioral health diagnosis, 3 or more emergency department visits or hospitalizations in the last 6 months. The PAL program is building upon this existing model by adding 3 additional PALs which would expand service to CareLink and out of care patients.

3. Are there any managed care organizations in your
collaborative? ○ Yes
○ No

3A. Please list the names of the managed care organizations in your

collaborative.
CountyCare

3A. If no, do you plan to integrate and work with managed care

organizations?
○ Yes
○ No

3B. Please describe your collaborative's plans to work with managed care organizations.

Cook County Health operates the CountyCare Medicaid plan.

11. Minority Participation

1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

All partners will have an active role in the implementation and continued work of this proposal. Our community partners are: Chicago Greater Food Depository, Housing Forward, BedsPlus, Heartland Alliance Health, WestCare, Live4Lali, and Safer Foundation.

FOR HEALTHCARE TRANSFORMATION PROPOSAL: PARTNER SCOPE OF WORK
Each partner agency working in these pillars agree to:
1. Assign/Hire Patient Advocate Liaisons (PAL) that will be connectors and navigators for patients requiring multiple health and wellness services (Full job description to follow upon grant award):
a. Provide walking hand-offs for patients between agencies when multiple services are needed
b. Utilize patient management technology system owned and sponsored by Cook County Health to coordinate a whole-person approach to healthcare
c. Case management for up to 60 patients
d. Participate in annual quality improvement assessments and planning
2. Agencies will both participate and provide trainings in their area of expertise to other agencies within consortium. Training will be compensated.
3. Provide Cross-training in all pillars outside of the work of employing agency
a. Understand vocabulary, practices, and policies of multiple pillars to accurately navigate patients across systems
4. Agree to be trained and use Cook County's technology/software for patient notes, etc. (training and assets provided by Cook County Health)

12. Jobs

Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

CCH is committed to Equal Employment Practices and makes every effort possible to recruit candidates who are representative of the communities we serve. Employment decisions are made on the basis of merit. In accordance with applicable law, CCH prohibits discrimination based on membership of an applicant or employee, in a protected class such as race, color, creed, national origin, ancestry, sex, gender, gender identity, gender expression, sexual orientation, age, religion, physical disability (including HIV or AIDS), mental disability, medical condition, marital status, citizenship status, military service status, or other consideration protected by law. CCH's policy of equal employment opportunity applies to all employment practices including, but not limited to, recruitment, employment, training, compensation, benefits, promotions, layoffs, terminations, and any and all other terms, conditions, and privileges of employment. In addition, CCH prohibits discrimination against any person or business due to a perception that a person or business representative is a member of a protected class or is associated with someone who is, or is perceived to be, a member of a protected class. All such discrimination is unlawful. CCH's commitment to equal opportunity employment applies to all persons involved in the operations of CCH and prohibits unlawful discrimination by any employee of CCH, including supervisors and co-workers. The Human Resource Department handles job postings through multiple methods to facilitate a diverse pool of applicants. Increasing diversity in hiring is a strategic goal for CCH and as such is included in the annual Strategic Plan.

All of our community partners are committed to maintaining a staff infrastructure which meets the evolving needs of the men, women and families we serve. To succeed, each agency monitors the best employment practices within the homeless service arena and human services arena, as well as observe local and regional hiring trends. One guiding principle is to incorporate diversity and inclusion in our client work, our leadership and our staff. This principle informs the continuous evolution of our employment activities, including a focus on hiring individuals from the communities we serve. The organizations' hiring and employment practices are a priority focus of the Organizational Development Committee of this project. This committee helps to establish and monitor all staffing objectives and benchmarks.

Inclusive language is always utilized in position announcements and lived experience and/or criminal justice background is highly valued in all job openings. Our partners understand that not all applicants are willing to share intimate information about their lived experiences and identities therefore, they advertise job opportunities in a multitude of media to attract a diverse pool of applicants. Diverse hiring practices are important to our partners. Some activities associated with this are: 1) developing relationships with schools offering specific degrees/majors (MSW, Counseling Psych, etc.); 2) establishing relationships with schools offering CADC prep programs; 3) reaching out to community organizations, recovery organizations, and student groups to promote diversity in hiring; and 4) recruiting in Historically Black Colleges and Universities.

New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

17 employees will be hired across CCH and partner agencies.

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

The PAL position is specifically targeted to represent individuals with lived experience and living in the communities that they serve. For example, a PAL hired by our housing partners will be someone who was housing insecure at some point in their life; a PAL hired by one of our substance use treatment partners will hire someone who has experience with substance use disorder. All positions that will be hired for this funding will target individuals that are from the communities represented by CCH and our community partners in an effort to create an equitable employment pathway.

4. Please describe any planned activities for workforce development in the project.

Each community partner will train their PAL internally and will go through the typical hiring process at that agency. What makes a PAL unique is that they will also be cross trained across sectors so they will have an overview of other agencies, challenges that those agencies face, as well as ways to overcome and connect patients. For example, if a patient screens positive for housing insecurity in a CCH hospital emergency department, a PAL would know enough about housing issues and be able to connect that patient with the PAL at a housing partner (i.e. Housing Forward, Beds Plus, Heartland Alliance Health) in real time to ensure that the patients' housing needs are met that day.

Conversely, if a patient who is seeking medicated assisted treatment (MAT) from a substance use provider does not have a primary care provider, our community partner would connect that patient to CCH. What makes this training transformative, is the CMIS system that allows for the "cross talk" among providers.

13. Quality Metrics

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

This proposal aligns with the HFS Quality Pillars by focusing on care coordination and the expansion of the technology platform. This builds upon CCH's commitment for high quality healthcare delivery by the enhancing the Care Coordination team that already serves CountyCare patients. This enhancement will allow the team to expand to service CareLink and out of care patients - some of the system's most vulnerable and costly patients. In addition, the existing CMIS technology platform will be available for our community partners to access so we can track our patients in real time, see what services- social and medical- that our patients need and are using and follow up when there is a loss of care. This is transformative healthcare delivery.

CCH'S PAL proposal aims to address the Department's Comprehensive Medical Programs Quality Strategy. Specifically, this proposal intends to fulfill the Better Care pillar by improve population health, improving access to care, and increasing effective coordination of care. This PAL program does this by improving participation in preventive care and screenings, promoting integration of behavioral and physical healthcare, creating consumer-centric healthcare delivery system, identifying and prioritizing to reduce health disparities, implementing evidence-based interventions to reduce disparities, investing in the development and use of health equity performance measures, and incentivizing the reeducation of health disparities and achievement of health equity. This application also seeks to deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration while transitioning to value- and outcome-based payment.

Overarching metrics that will be monitored over the course of this grant are: Medicated Assisted Treatment (pharmacotherapy) for Opioid Use Disorder (MAT), Visits to the Emergency Department Visit for Behavioral Health Services That Result in Hospitalization, Overall Number and Length of Behavioral Health Hospitalizations, Number of Repeat Behavioral Health Hospitalizations, C-Section Rate for Low-Risk Women with No Prior Births, Well-Child Visits in the First 30 Months of Life (W30), Child and Adolescent Well-Care Visits (WCV), and Childhood Immunization Status (CIS)— (Combo 10) among others.

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child
Health? ○ Yes
○ No

Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.
This proposal will utilize the Access to Care Measures Performance, Prenatal and Postpartum Care and Keeping Kids Healthy Measures Performance.

2B. Adult Behavioral
Health? ○ Yes
○ No

Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.
This proposal will use the Behavioral Health Measures Performance and Pharmacotherapy for Opioid Use Disorder.

2C. Child Behavioral
Health? ○ Yes
○ No

Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

2D.
Equity? ○
Yes
○ No

Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.
This proposal will include Access to Care Performance Measures.

2E. Community-Based Services and
Supports? ○ Yes
○ No

Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.
This proposal will include Access to Care Performance Measures.

3. Will you be using any metrics not found in the quality
strategy? ○ Yes
○ No

3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.
The CCH PAL proposal will work closely with the Quality Department at CCH and will track health outcome measures that are currently required by CMS Star Rating. These metrics include: patient experience, readmission rates, mortality, safety of care, timeliness of care, effectiveness of care, and use of medical imaging.

14. Milestones

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

Cook County Health intends for a 6-month planning period to work with partner agencies on the development, refinement and implementation of the PAL program. This planning period would include any budgetary adjustments that may need to take place, contract agreements to be approved, hiring processes, and procurement of services. In Years 3-5, the continuation of service provision as well as evaluation of process-based outcomes via the Rapid Cycle Quality Improvement (RCQI) as well as the monitoring of quality metrics outlines in the Quality Metric (13) section. Attached is a proposed work plan that is subject to change based on partner availability and continued collaboration of work.

15. Budget

1. Annual Budgets across the Proposal

2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

Year 2 Individuals
Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

Year 3 Individuals
Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

Year 4 Individuals Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

Year 5 Individuals Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

Year 6 Individuals
Served

60 patients per PAL, 14 PALs hired with a total of 840 potential patients

3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

Alternative payment methodologies does not apply to CCH as we would use the directed payment structure already in place.

16. Sustainability

Provide your narrative here:

Long-term sustainability of PAL implementation and increased healthcare access in medically underserved areas is a high priority for the health system. CCH will integrate the proposed strategies into the current training models and transition the trainings to CCH's regular functions. The sustainability and autonomy of the proposed project beyond the funding period will be achieved through in-house support for continuing education for residents and faculty. Additionally, by establishing novel and innovative hiring practices and educational opportunities for PALs, CCH will increase the diversity and uniqueness of its Care Coordination program, workforce development and retention of staff.

During the funding period, self-sufficiency will include progress towards the on-going development of the project's operational materials and staff training by the end of each project year. In the final year of the project, the PAL project management team will build in key roles and responsibilities into existing positions in Care Coordination department at CCH. The identified individuals in the project already hold leadership positions, and their current duties reflect the responsibilities needed for the PAL program. By building in additional tasks, ones that mimic roles they already hold, the PAL program will become engrained into the current structure of the Care Coordination department. This will begin Year 1 of the project with the goal of becoming completely self-sufficient by the end of the funding cycle in Year 5. Additional funded positions will be slowing absorbed into the CCH system (i.e. PALs, evaluator, project manager, data analyst) at a rate of 10% per year therefore establishing a CCH position for all grant funded employees by Year 5. All other staff are already employees of the CCH system and will be dedicating part of their time to the project.